# DEVELOPMENT OF SOUTHAMPTON ADAPTATION FRAMEWORK FOR CBT (SAF-CBT): A FRAMEWORK FOR ADAPTATION OF CBT IN NON-WESTERN CULTURE

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## ABSTRACT

**Objective:** To develop guidelines for adaptation of CBT in Pakistan.

**Design**: Mixed methods ( both qualitative and quantitative).

**Place and Duration of Study:** The studies were carried out in two cities in Pakistan, Rahim Yar Khan and Lahore, between October 2006 and March 2009.

**Subjects and Methods**: We conducted in depth interviews with psychologists and with depressed patients and group discussions with University students. A thematic content analysis of information from these interviews and field and therapy notes was carried out to develop guidelines.

**Results**: Themes and subthemes from different studies were compared with each other as well as with information gleaned from field and therapy notes. This information was organized in the form of an adaptation frame work. The framework consists of three themes; culture, capacity and cognitions, with each theme further divided into seven subthemes. This framework guided development of a culturally sensitive CBT manual which was later tested in a pilot project and adapted CBT was found to be effective in reducing symptoms of depression in Pakistan.

**Conclusion**: Our work confirms some of the factors described for adaptation of therapy in previous guidelines which were developed in the West. However, we found that factors in addition to therapy itself need to be considered when adapting therapy in a given culture, for example the barriers posed by health system. In this paper we are describing the adaptation framework.

**Key words:** Cognitive therapy, Cultural sensitivity, Manualized CBT, Depression, Pakistan

## INTRODUCTION

Cognitive behaviour therapy (CBT) has been found to be effective for the treatment of depression in the western world[1,2,3] and is recommended for the treatment of psychiatric disorders in National Treatment Guidelines in the UK[4] and the USA[5]. However, it is not widely available in developing world. In our literature search we found only one published RCT of CBT for depression[6]. We also found one study in which brief CBT was compared with stepped care for medically unexplained symptoms[7] and another study which compared a CBT based intervention for the depressed mothers and their infants, against care as usual[8,9].

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It has been suggested that cultural differences can influence the process of psychotherapy and therefore therapy might need adapting to the cultural needs of a given country[10,11,12,13,14]. Some therapists working in the West have developed guidelines for adaptation of psychotherapy for ethnic minority clients[15,16,17,18], while Pamela Hays[19] has proposed a framework for therapists using CBT. It has been suggested that when developing adaptations the following steps should be followed; (a) information gathering,(b) preliminary adaptation design, (c) preliminary adaptation tests, and (d) adaptation refinement[20].

In this paper we are describing an adaptation framework (Southampton Adaptation Framework for CBT) which was developed in Pakistan. It was a two stage project whose aim was to establish whether CBT can be an acceptable, accessible and effective treatment for depression in a developing country. The first stage of the project comprised of a series of studies to develop and refine a CBT manual to treat depression. This comprised of interviews with psychologists[21], depressed patients[22] and university students[23], therapy with patients and field observations. The framework guided development of a CBT for depression manual which

was used in a pilot trial[24] and was found to be effective in reducing symptoms of depression against care as usual.

## METHODS

We have described the methodologies used for each study in relevant publications. Here we are going to describe only relevant issues briefly. This was a mixed method study. We used the guidelines described in literature[20,25,26] for adapting CBT for depression in Pakistan. Through our qualitative work we developed 28 sub themes, which were reduced to 21 during the next step of analysis which was carried out after the literature review. These sub themes were grouped into three major themes. Table 1, gives some examples of the categories which were the basis of our sub themes.

**Table 1: Some examples of categories which were used to develop the framework**

| Psychologists study | Patients study | Field observations |
|---|---|---|
| • People come from different areas, they are usually illiterate and belong to the lower social class<br>• They usually have a diagnosis of depression or anxiety and present with physical complaints or with conversion<br>• If a person is depressed I will help him to improve his activities by using behavioural techniques<br>• As soon as a patient becomes symptoms free he stops seeing us<br>• For illiterate patient coming from outside Lahore therapy lasts over hardly one or two sessions<br>• Women are more likely to drop out of therapy than men<br>• In Pakistan the family is too much involved with the patients and sometimes it can be a big problem<br>• Patients like direct advise<br>• Patients find it difficult to understand some concepts, for example, cognitive errors<br>• Patients are more interested in medicines. May be they are not expecting this kind of therapy. They are expecting only medicines from here<br>• One big problem is that patients usually go to see the religious healers. The reason they see the religious healers is because they believe their illness is due to Jadu (Magic)<br>• Doctors do not even know anything about cognitive therapy<br>• Patients think it's a bit of chit chat. They don't take it seriously | • I get headache and dizziness. I also feel weak, my arms feel numb.<br>• I cannot stop working. I have to look after my family<br>• I don't know the name of my illness<br>• It is "some sort of physical illness", 'illness of poor sleep' and 'tension'<br>• I have this illness due to the problems in my life<br>• I don't know about psychologists<br>• Only a doctor can treat my illness<br>• Whatever doctor tells me or the tests he suggests or the good quality medicines he prescribes will be good for me. That will be the treatment<br>• I have not heard of psychotherapy or treatment without medicines<br>• Mental illnesses are the illnesses which are due to worries and trauma<br>• Mental illnesses are due to problems at home and at work<br>• Nearly all the patients were referred by themselves or by a friend or a family member | • I have a ball of gas in my stomach which rises to my head and then I start feeling dizzy (a patient with anxiety)<br>• Patients come from far off places. It might take up to two days for a patient who is travelling to a big city.<br>• Mental illnesses are due to sins (One medical colleague)· My son got married few months ago. His attitude has changed. My daughter in law has put magic spell on him (a depressed patient)<br>• How can she be depressed? She has got everything she can imagine (husband of a depressed patient who was informed she had depression)<br>• When I refer patients to see a psychiatrist they usually refuse because of the stigma. So I have to treat them myself (a cardiologist)<br>• The health service is poorly structured and specialist services are only limited to the big cities. There is no referral system. Patients mostly refer themselves<br>• Patients like instructions rather than a collaborative approach<br>• There is no word in Urdu or any local language which describes "assertiveness"<br>• Expressing your opinion, when talking to a senior or an elder, until and unless you are in agreement, is not seen as a positive value<br>• Most patients want a cure with a single treatment. |

## RESULTS

We are describing the themes; culture, capacity and cognitions and subthemes here.

- **Culture**

***1. Culture, religion and spirituality***

Religion and spirituality are important parts of peoples' lives in many Asian cultures, influence people's belief system and therefore are important in expression of distress, theories of causes of illness and health seeking behaviours. Culture, religion and spirituality can also give rise to myths and stigma attached to illness. For example, many people in Pakistan believe that not following religion can make people depressed. Culture and religion also influence beliefs about the "causes & effects" of day-to-day events. For example, a magic spell or an evil eye (nazar-e-bad) is often blamed for the misfortunes or a mishap. This has important implications when giving therapy to a patient in Pakistan. Religion also influence the way we cope with distress; for example, reciting the Qur'an and using charm lockets, talismans, and tavees (armlets) or practice of religious rituals or repetition of religious mantras (e.g., "wird" or Wazifa"). However, it should be noted that there are wide cultural variations among different groups in Pakistan. Differences between Pathan and Punjabi cultures are readily noticeable.

***2 Family***

Family can be both a source of stress or support. Sometimes patients talk freely only when they are seen on their own and may not express themselves when a family member is around. There is usually one decision maker in each family. Approaching the decision maker can ensure cooperation and future follow up. It is important to keep in mind the "secrets" within families. Secrets are fairly common and can involve issues around marriage, love affairs or even an illness.

***3. Communication and Language***

Most people don't seem to be much interested in writing (for example a tailor is less likely to write down measurements). This certainly has implications in terms of homework for therapy. Being "respectful" might mean a person should not openly disagree with his elder (Sometimes patients might not disagree with the therapist due to respect, however, they might show their disagreement by not turning up for their next appointment). When disagreeing with a person in authority people use phrases like, "with a big apology, I would like to seek your permission to disagree, with due respect I would like to say" (apology technique). People using this technique also adopt a body language symbolizing humility (for example lowering their gaze). Urdu, the national language of Pakistan is not the native language of any native groups (http://en.wikipedia.org/wiki/Urdu). Therapists said patients find literal translation of terminology difficult to understand.

***4. Rules of engagement***

Developing a therapeutic relationship becomes even more important in this context. People go to see healers because of faith rather than reason and word of mouth is an important contributory factor in referral process. Once the patient or his family is convinced that the therapist has "healing powers", follow up becomes an easy task. Patients can freely choose their therapist and therefore establishing a trusting relationship during the first couple of sessions might be of paramount importance.

***5. Expression of distress & symptoms***

Many patients with anxiety or depression present with physical complaints in Pakistan. Locally used idioms of distress give us some further insights, for example, when under stress people often say; passenay choot gay (profuse sweating), dil doob gaya (sinking of heart), zamin peron talay say nikal gai (earth moved from underneath my feet), ankhon talay andhera cha gaya (everything turned dark), oopar ka sans oopar neechay ka neechay reh gaya (breathing stopped).

***6. Focus of therapy***

A therapist who is trained in Western therapy techniques alone might find himself out of his depth when dealing with patients who present with somatic complaints, especially since techniques to address somatic or dissociative symptoms are not well developed. CBT puts great emphasis on structuring sessions around patients' needs and focusing on somatic complaints might be helpful.

***7. Traditional healing practices***

Mental health professionals in Pakistan felt that seeing traditional healers causes hindrance in therapy. None of the patients in our study admitted to seeing a traditional healer. However, this could be due to their fear that doctors do not want to hear about traditional healers, rather than a lack of contact. The multi-dimensional approach used by patients in Pakistan is apparent in seeking multiple sources of help usually simultaneously. Their model of illness is similar to a bio-psycho-social model used in Western mental health practice. For instance, a patient may consult a GP and also see the Imam for prayers. In fact a patient might be seeing a doctor because he has been referred by a faith healer. We know from our experience that in some situations working in alliance with the faith healers improves the compliance to treatment

- **Capacity and circumstances**

Although some of the areas in this domain are not entirely new, they are probably different in their significance.

*Individual level*

***1. Gender***

Women from this cultural background have a lesser degree of autonomy than their western counterparts.

This can mean they have to seek permission from their husband or father to see a therapist, to be brought for sessions and change the way they do things. Women might also feel uncomfortable when seeing a male therapist. Men on the other hand can travel more, are in control of finances and are more educated than women.

***2. Age***

Age of the patient can be an important variable in therapy. In our experience younger patients are more likely to benefit from therapy. Exposure to higher level of education, access to electronic and print media, and internet might be contributory factors. It might also be possible that younger patients are more aware of western concepts of mental illness and its treatment.

***3. Educational level***

Homework often involves reading informational material or self-monitoring and completing activity schedules, thought diaries and thought records. This can require a degree of reading and writing skills. Most families have a member who is literate.

***4. Coping strategies***

An important component of CBT is to reactivate or teach new coping skills. Asian patients are more likely to use religious and spiritual coping skills.

*System level*

***5. Capacity of the health system***

Patients who present to the health facilities come from distant areas. This means many patients might not be able to attend weekly sessions of therapy. Mental health professionals see high number of patients in their outpatient clinics (number can reach more than 100). This means professionals have hardly any time to communicate with their patients. Other factors which need consideration when adapting interventions might include; resources both human and financial, system's ability to absorb and adopt new ideas and interventions and political will and stability.

***6. Mental health professionals***

There are nearly 400 psychiatrists in Pakistan (for a population of 160, million). The number of "clinical psychologists" working in public health sector is even smaller (in spite of the fact that most universities run master programmes in psychology. There are 12 such universities in Lahore). There is currently no Cognitive Behaviour Therapist in Pakistan. Attitudes of professionals are important in this regard. Psychiatry in Pakistan is very biological in orientation.

***7. Pathways to care & help seeking behaviours***

Pathways to care adopted by patients are different than those adopted by their counterparts in west and in turn might be related to multiple factors, e.g.; sociodemographic factors, social structures, level of education, cultural beliefs and practices, gender discrimination, status of women, economic and political systems environmental conditions and the disease patterns and the health system itself.

- **Cognitions and Beliefs**

***1. Beliefs about health and illness***

Patients' ideas of health might be different from our ideas. A patient who believes that feeling depressed is normal because of circumstances is less likely to seek help for depression or anxiety. Similarly, it is possible that people think of normal health as comprising only of physical health. It is possible that people with somatic symptoms go to medical healers, while those with psychological symptoms go to faith healers or spiritual healers.

***2. Beliefs about causes of illness***

A patient, who believes that his depression is caused by his sins, is less likely to see a doctor. Patients in our study believed in a psycho-social model of illness. However, probably because of their somatic symptoms they presented to the doctors. The label of physical illness can avoid negative stigma.

***3. Beliefs about treatment***

Beliefs about causation of an illness can influence our decisions about choice of treatment and engagement with services. Patients in Pakistan often look for a cure. They also wanted immediate relief. All the patients in our study said they will benefit from "good tests" and "quality medicines". Patients who come to see psychologists are always on medicines. Patients in Pakistan may be more likely to expect medication for the treatment of depression and other psychological problems and may have less knowledge about other kinds of interventions that may be available to them.

***4. Beliefs about health systems***

Patients expectations from the health system are probably the outcome of their beliefs about the health system. These beliefs are also responsible for their " trust" in health systems (which possibly reflects their trust on the whole system). It is common for patients to go to doctors who they can trust (for example seeking help from a doctor who belongs to patients' village, city, sect, religious or linguistic group).

***5. Beliefs about healing and the healer***

When a patient was asked "can you tell me what is wrong with you?", the reply was, "you tell me, what is wrong with me, you are the doctor". Finding out, what a patient thinks about doctor's powers and his limitations can be important.

***6. Beliefs about psychotherapy***

Patients in Pakistan were simply not aware of any non pharmacological treatment available. Sufism (Is-

lamic version of mindfulness) is widely practiced by faith healers in Pakistan. Therefore they are not naive to psychological interventions. It is just that their idea of psychological intervention might be of an intervention that we call "mindfulness" and which they do not expect in a medical setting.

### *7. Cognitive errors and dysfunctional beliefs*

Dysfunctional beliefs and cognitive errors might vary from culture to culture[27]. There is some evidence from Hong Kong[28] and Turkey[29] that this might be the case. Role performance within family, familial harmony, fate, face and fairness were described as culture specific themes in the study from Hong Kong[28]. In our work we found that, dependence on family, giving up personal needs for the good of the family or the need for acceptance by others are widely shared by the healthy individuals in Pakistan.

## DISCUSSION

As far as we are aware this is the first framework for the adaptation of a psychological intervention which is based on systematic observations carried out in a developing country, which was used to adapt a CBT manual that was later tested in a pilot project. Previously published frameworks were developed mainly in the West for adapting therapies for ethnic minority patients in the west. We followed the existing guidelines for adapting CBT in Pakistan. Our work confirms some of the factors described in earlier frameworks for example, focusing on communication, cultural issues, orienting clients to therapy, cultural beliefs about mental illness, its causes and treatment, therapeutic relationship, religion and spirituality, age and gender and expression of distress. However, the major limitation of these frameworks was in their emphasis on therapy factors and ignoring or undermining factors related to health and health system. This is however understandable when one considers the fact that therapists working in the west are working in well established health systems. In the context of developing countries issues related to health and social support system as well as resources are equally important.

This is just the beginning of adaptation work. Adapted version of CBT needs to be tested in larger trials. We believe that this work can be repeated in other countries using the methodology we have used.

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